

<b>Case Number:</b>	CM15-0096367		
<b>Date Assigned:</b>	05/26/2015	<b>Date of Injury:</b>	05/23/2014
<b>Decision Date:</b>	06/30/2015	<b>UR Denial Date:</b>	04/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/19/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 30-year-old male who sustained an industrial injury on 5/23/14. Injury occurred while he was pulling a large container of trash. The 7/16/14 lumbar spine MRI impression documented three broad-based disc extrusions from L3/4 through L5/S1. L3/4 is right eccentric and L4/5 and L5/S1 are left eccentric. Findings documented left L5 nerve root impingement at the L4/5 level and left S1 nerve root displacement and compression at L5/S1. The 4/15/15 treating physician report cited grade 5/10 low back pain radiating down the left leg. Pain increased with walking. Physical exam documented 30% loss of lumbar range of motion with normal deep tendon reflexes and decreased left L5 and S1 dermatomal sensation. The assessment included large L4/5 and L5/S1 disc herniations on the left with left lower extremity radiculopathy. He had two epidural steroid injections with no lasting relief. The treatment plan recommended left L4/5 and L5/S1 decompression surgery with a hot & cold unit and a muscle stimulator. The 4/23/15 utilization review certified the request for left L4/5 and L5/S1 decompression. The associated requests for a hot and cold unit and a muscle stimulator were non-certified as there was no indication for their necessity and lack of guideline support.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Post operative Hot and Cold unit: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold ([http://www.aetna.com/cpb/medical/data/200\\_299/0297.html](http://www.aetna.com/cpb/medical/data/200_299/0297.html)).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Chapter 12 Low Back Disorders (Revised 2007), Hot and cold therapies, page(s) 160-161.

**Decision rationale:** The California MTUS are silent regarding hot/cold therapy devices, but recommend at home applications of hot or cold packs. The ACOEM Revised Low Back Disorder Guidelines state that the routine use of high-tech devices for hot or cold therapy is not recommended in the treatment of lower back pain. Guidelines support the use of hot or cold packs for patients with low back complaints. Guideline criteria have not been met. There is no compelling reason submitted to support the medical necessity of a hot/cold therapy unit in the absence of guideline support. Therefore, this request is not medically necessary.

**Post operative Muscle stimulator:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation (NMES Devices) Page(s): 121.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

**Decision rationale:** The California MTUS guidelines for transcutaneous electrotherapy do not recommend the use of NMES in the treatment of chronic pain. Galvanic stimulation is considered investigational for all indications. Guidelines suggest that interferential current is not recommended as an isolated intervention. Patient selection criteria is provided if interferential stimulation is to be used despite lack of guideline support and includes ineffective pain control due to diminished effectiveness of medications, intolerance of medications, history of substance abuse, post-operative pain limiting functional ability, and failure to respond to conservative measures. Guideline criteria have not been met for the use of a muscle stimulator. There is no indication that standard post-op pain management would be insufficient. There is no documentation that the patient was intolerant or unresponsive to pain medications during the pre-operative period. If one or more of the individual modalities provided by this multi-modality unit is not supported, then the unit as a whole is not supported. Therefore, this request is not medically necessary.